Provider Profile PIN:

Connecticut Vaccines For Children Program

All public and private health care providers who receive vaccine from the Connecticut Vaccines for Children Program **(VFC)** must complete this form. This document provides shipping information and helps to determine the amount of vaccine to be supplied. The form is also used to compare estimated vaccine needs with actual vaccine supply. The Immunization Program will keep this record on file with the SIGNED **"*Provider Agreement"*** on the back of this page. The Provider Profile form must be updated annually or if: (1) the number of children change, or (2) the status of the facility changes.
One form needs to be completed for each office/site/satellite.

Federal Employer Tax ID: _____ Group Medicaid Billing Number: _____

Please provide the following information for all personnel who administer vaccines.

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

Physician _____ CT License # _____ Medicaid Billing # _____

RN, APRN _____ CT License # _____ Medicaid Billing # _____

Other _____ Other License # _____ Medicaid Billing # _____

Shipping Address:
Facility/Provider Name: _____

Contact Person: _____

Street Address (no P.O. Boxes): _____

City, State, Zip: _____

+Phone # _____ Fax # _____

+If possible, we would like this number to be a direct line to the person who orders the vaccines.

Office Days and Hours: _____

Indicate the Type of Facility (please check one only):

_____ 10 Public Health Department
_____ 12 Public Hospital
_____ 16 Other Public (please specify: _____
_____ 15 Federally Qualified Health Center (FQHC) or federally funded Rural Health Clinic
_____ 20 Private Practice (Individual or Group)
_____ 22 Private Hospital
_____ 24 Other Private (Please specify _____

	Birth to 2 yrs	3-6 yrs	7-18 yrs	> 18 yrs	Total
* Total Patients in practice needing Immunizations(by age):	_____	_____	_____	_____	_____

* How many children entered above are in the following categories:
(Please do not count a child in more than one category or use percentages.)

	Birth to 2 yrs	3-6yrs	7-18 yrs	Total
31 Enrolled in Medicaid	_____	_____	_____	_____
32 Without health Insurance	_____	_____	_____	_____
33 American Indian or Alaskan Native	_____	_____	_____	_____
44 Underinsured	_____	_____	_____	_____

(Complete ***44 Underinsured*** only if this is an FQHC, an agent of an FQHC or an RHC (see 15 above)

* These numbers must be entered in order to receive vaccines. New providers should give an estimate.

PLEASE remember to sign the ***"Provider Agreement"*** on the back of this page.

In the future, we may use e-mail for some communications; please give us the e-mail address for your facility.

_____@_____

Return to: State of Connecticut, Department of Public Health
410 Capitol Avenue, M.S. # 11MUN Hartford, CT 06134-0308